STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	C 07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of three Complaint Investigations (2835102, 2817793, 2806775) conducted at Rainier School PAT C on 05/17/13, 06/26/2013 and 07/17/2013. A sample of three residents were selected. The investigation was conducted by: [redacted], R.N., B.S.N. [redacted] R.N., B.S.N. The investigation team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: 360-725-2405 Fax: 360-725-2642	W 000	RECEIVED SEP 13 2013 DSHS/ADSA/RCS/BAAU	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interviews and record reviews facility failed to follow policy SOP (Standard Operating Procedure) 3.18 Social Leave for 1 of 1	W 111	W 111 Client Records Rainier School will revise SOP 3.18 to include updated processes for notification of vacation leave and documentation included on Share point PERSON RESPONSIBLE: DDA/DDA2 MONITOR: QA 09/17/13 Resident 1's file will be revised to include documentation of social leave that occurred in August. PERSON RESPONSIBLE: ACM MONITOR: DDA2 9/1/13 Email notification of requirements for staff to Document social leave in progress notes to core team staff From DDA2 And monitoring of required notes will be review by the QIDP at Q review time when a social leave occurs. PERSON RESPONSIBLE: DDA1 MONTOR: DDA2 9/16/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 Residents (Resident #1) when Resident #1 went on leave with guardian from July 5, 2013 to August 4, 2013. Failure to follow policy SOP 3.18 created a potential for staff to have no knowledge of the resident ' s whereabouts from lack of documentation. Findings include: Record review on 07/17/13 revealed that the SOP 3.18 Social Leaves policy reads that if a resident is gone one or more nights away from campus for purposes other than medical, house staff are to record in progress notes the times the client leaves and returns. Obtain the signature of the person who picks up the client in the Visitors ' Log. The guardian/family is to pick up medications at Pharmacy and the Vacation Medication Record. Record review on 07/17/13 revealed that Resident #1 had fallen on 06/28/13 and had sustained a cut to the [redacted] which required stitches. Resident was to follow up with the physician in a week and nursing were to monitor for infection. There was no documentation in Resident #1 ' s file that guardian/family were notified of the incident and Resident #1 sustaining a laceration that required stitches. No documentation was in the Resident #1 ' s progress notes to alert staff that Resident #1 was on leave with guardian/family from July 1, 2013 to August 4, 2013. There was no documentation in Resident #1 ' s file to reflect who were aware of the treatment of the Resident #1 ' s wound or as to when the stitches were to be removed.	W 111	Doctor verbal orders written for wound care while client was on vacation Were listed on doctors orders and shared with guardian verbally. Documentation will occur by the RN on duty at the time of departure Should continued medical care be required that it was Shared with the guardian. Monitoring of that documentation will occur by the QIDP via Q review. PERSON RESPONSIBLE: QIDP/RN MONITOR: DDA1 7/1/13 Notification of hospital trip and sutures was completed by the hospital for guardian approval of care as client left via ambulance from the scene process of notification will continue when accessing medical care in the community PERSON RESPONSIBLE: Nursing MONITOR: RN4 6/28/13	

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W 111	Continued From page 2 Interview with the ACM (Attendant Counselor Manager) on 07/17/13, revealed that Resident #1 ' s [redacted] is a nurse practitioner and the [redacted] would be monitoring the wound and remove the stitches in 14 days from the date of insertion as ordered by the physician. ACM also stated that the guardian/family had met with the pharmacy and had gone over the medications with them and had received enough medications for the resident until his return to the facility on August 5, 2013. None of this information was documented in Resident #1 ' s file. Review of Resident #1 ' s file did not reveal documentation to indicate date and time of when resident left , that medications had been reviewed and given to the guardian prior to going out on leave, nor that Resident #1 ' s [redacted] was going to be monitoring the Resident #1 ' s wound and would be removing the stitches when the physician indicated.	W 111		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, facility failed to ensure 1 of 1 residents (Resident #2) movement was not restricted while in his wheelchair. This failure to explore and implement less restrictive practice resulted in a	W 128	W 128 Protection of Client Rights	

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W 128	Continued From page 3 situation that restricted resident ' s mobility and created a potential for harm and injury should resident attempt to self-propel using his legs and potentially causing wheelchair to tip over. Findings include: Interview and record review on 06/26/13 revealed that on 05/06/13 Resident #2 was in his wheelchair and had a follow-up appointment with his primary physician (Staff C). When Staff A attempted to transport Resident #2 to the clinic for his appointment, she noted that Resident #2 ' s foot would fall off the foot rest of the wheelchair and fall under the wheelchair potentially causing an injury if residents foot got caught, therefore Staff A tied the residents legs together using a gait belt so that Resident #2 ' s legs would not fall off the footrests. Staff D stated in her interview on 06/26/13, that Staff D did not see the gait belt in place, however Staff D did note that the gait belt had been being used by strapping the gait belt to the foot rests to prevent Resident #2 ' s feet from falling back through the foot rests and potentially causing an injury. Record review on 06/26/13 revealed that Resident #2 has had 5 falls with injury out of his wheelchair between 09/20/12 and 05/26/13 and has a decline in his overall mobility status. Per the Facility Investigation report Staff B stated that the staff had been using a gait belt on Resident #2 ' s wheelchair for months due to a broken footrest. Staff A had been observed 2 times by Staff B on 05/06/13 attempting to take Resident #2 to the clinic for his appointment when his right foot would fall off the footrest and fall under the wheelchair. Staff A then placed the gait belt	W 128	PAT C house staff will be in-serviced SOP 3.12 Use of Restrictive Procedures and SOP 3.13 Adaptive Equipment and Mechanical Supports PERSON RESPONSIBLE: ACM MONITOR: DDA2 05/29/13 Resident 2 was placed on PRO status and Ad Hoc was held to review resident 2 needs and provide clear direction for staff with PT and PCP PERSON RESPONSIBLE: HPA MONITOR: DDA2 06/03/13 Staff A received an Oral Reprimand and in-servicing on SOP 3.12 Sue of Restrictive Procedures and SOP 3.13 Adaptive Equipment and Mechanical Supports for using protective Restrictive procedures without due process for resident 2 PERSON RESPONSIBLE: DDA2 MONITOR:DDA2 06/13/13	

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W 128	Continued From page 4 around the resident calf ' s to secure his legs in order to get him to the clinic. When Resident #2 arrived at the clinic accompanied by Staff A, the restraint was identified by Staff C (Physician) who notified all the proper authorities.	W 128		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure staff reported an allegation of physical and verbal abuse for 1 of 1 resident (Resident #3) to facility management and the State Complaint Resolution Unit (CRU) timely. Failure to make timely reports prevents the facility and State Investigative Agency from having immediate knowledge of an incident, which places the resident at further risk of abuse. Findings include: Record review on 06/26/13 revealed that on 05/26/13 there had been a complaint from a community member that Staff E had been physically and verbally abusive toward Resident #3 while resident was in the ER (Emergency Room) waiting room waiting to go back into a room to be seen by a physician. Community member stated during a phone interview on 07/01/13 she felt that the Staff E was overwhelmed and didn ' t quite know what to do	W 153	W 153 Staff Treatment of Clients Rainier School will continue to report Any allegations of neglect, mistreatment or abuse to the administrator/facility or to other officials in accordance with State law through established procedures. Staff F was instructed to report immediately all instance of allegations of abuse and neglect by area director. Rainier School will provide yearly in-service training on Abuse and Neglect reporting emphasizing the importance Of reporting immediately. PERSON RESPONSIBLE: DDA/DDA2 MONITOR: ADMIN 08/01/13	

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W 153	Continued From page 5 with Resident #3 while he was having behaviors. Community member stated that Resident #3 was hitting and spitting at Staff E and trying to put himself on the floor. Community member stated that Staff E appeared to have an arm on Resident #3 ' s chest, Staff E ' s legs against Resident #3 ' s, and Staff E ' s arm on Resident #3 ' s thighs trying to prevent Resident #3 from going out of the chair. Community member stated that she went outside and called her friend (Staff F) who worked at the facility, but stated that Staff F person was unable to provide any help. Staff F was new the facility and had only been there approximately six months and told the community member that Staff F did not have a number to the facility. The community member was under the impression that Staff F would report this incident the next day when F went to work (Staff F did not report to work until 05/28/13 as 05/27/13 was a holiday). The facility investigative report shows that Staff F notified her supervisor the morning of 05/28/13 and was told that she needed to initiate an incident report at that time.	W 153		